CHAPTER 9 MEDICAID PROGRAM

900 TIME LIMITATION ON PAYMENT OF MEDICAID PROVIDER CLAIMS

900.1 Provider claims for reimbursement shall not be honored if they reach the payment agency more than ninety (90) days after the date of service, except as otherwise provided in this section.

900.2 The time limitation shall not apply to retroactive adjustments paid to providers that are reimbursed under a retrospective payment system.

900.3 If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim or residual relating to the same services within six (6) months after the agency or provider receives notice of the disposition of the Medicare claim.

900.4 The time limitation shall not apply to claims from providers under investigation for fraud or abuse.

900.5 The agency shall make payments at any time in accordance with a court order; to carry out hearing decisions or agency corrective actions taken to resolve a dispute; or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

900.6 The time limitation shall not apply when it can be established that billing to a third party delayed submission of the claim.

900.7 The time limitation shall not apply to the Medicaid eligibility spend-down provisions.

900.8 The time limitation shall not apply to retroactive Medicaid eligibility determinations.

900.9 The time limitation shall not apply to health maintenance organizations (HMOs) or prepaid capitation grants.

900.10 The time limitation shall not apply to providers that are located outside of the metropolitan area who provide services to Title XIX eligibles.

900.11 The time limitation shall not apply to services for foster children or services to wards of the District.

900.12 The time limitation shall not apply to individuals who apply for Medicaid on the basis of disability.

901 MEDICALLY NEEDY INCOME LEVELS

901.1 The medically needy income levels for the District Medicaid program shall be the following:

PERSONS	MONTHLY INCOME	SIX-MONTH INCOME	TOTAL AMT. RESOURCES
1	$ 348.00	$ 2,088.00	$ 2,500.00
2	366.00	2,196.00	2,600.00
3	466.00	2,796.00	2,700.00
4	569.00	3,414.00	2,800.00
5	665.00	3,930.00	2,900.00
6	770.00	4,620.00	3,000.00
7	883.00	5,298,00	3,100.00
8	977.00	5,862.00	3,200.00
9	1,074.00	6,444.00	3,300.00
10	1,167.00	7,002.00	3,400.00
11	1,231.00	7,386.00	3,500.00
12	1,323.00	7,938.00	3,600.00
13	1,385.00	8,310.00	3,700.00
14	1,461.00	8,766.00	3,800.00
15	1,514.00	9,084.00	3,900.00
16	1,591.00	9,546.00	4,000.00
17	1,746.00	10,476.00	4,100.00
18	1,786.00	10,716.00	4,200.00
19	1,822.00	10,932.00	4,300.00

902 ASSIGNMENT OF MEDICAL SUPPORT RIGHTS

902.1 As a condition of eligibility for Medicaid in the District, an individual shall, in accordance with 42 CFR 433.146 through 433.149, do the following:

(a) Assign any rights to payment for medical care support available under an order of a court or an administrative agency, and any third party payments for medical care to the District. Right to payment must be assigned by the individual for himself or herself and for any other person eligible for Medicaid on whose behalf the individual has legal authority to execute assignment of those rights; and

(b) Cooperate with the District in establishing the paternity of any children born out of wedlock for whom he or she seeks Medicaid eligibility.

903 OUTPATIENT AND EMERGENCY ROOM SERVICES

903.1 The Department shall pay for all outpatient and emergency room visits at a fixed rate based on each hospital's fiscal 1980 costs, as reflected in that hospital's cost report filed with the Office of Health Care Financing, plus nine percent (9%). The base rate shall be subject to adjustment when the audit of the 1980 cost report is completed.

903.2 The rate established under §903.1 shall be used for all visits occurring after September 17, 1982.

903.3 Outpatient and emergency room services rendered by a hospital prior to September 17, 1982, shall be reimbursed in accordance with the existing reimbursement method.

903.4 The Department shall negotiate a utilization "target" with each hospital for the twelve (12) month period beginning September 17, 1982. Utilization in excess of the target figure shall be paid for at a lower rate.

903.5 For the emergency room patient who is admitted to the hospital as an inpatient, the actual emergency room charges shall be added to the inpatient claim.

904 SKILLED OR INTERMEDIATE NURSING CARE FACILITIES

904.1 In recognition of the fact that many Medicaid patients require more nursing care than the program presently will pay for, and therefore, it is difficult to locate sufficient placements for Medicaid patients, effective not later than June 5, 1983, the District Medicaid program shall eliminate the present ceiling on the number of allowable nursing hours that may be claimed for reimbursement. While this action will increase federal reimbursement for District long term care facilities, this increase will be offset by increased costs for placements.

905 MEDICAID REIMBURSEMENT TO OUT-OF-STATE SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

905.1 Payment to a nursing home located outside of the District of Columbia serving D.C. Medicaid patients shall be inaccordance with the rate schedule that applies to a nursing home provider under the Medical Assistance Program of the state where the nursing home is located. This rule does not apply to Forest Haven.

905 MEDICAID REIMBURSEMENT TO OUT-OF-STATE SKILLED NURSING AND INTERMEDIATE CARE FACILITIES (Continued)

905.2 This rule shall become effective on the beginning date of each facility's fiscal year occurring on or after January 1, 1985.

905.3 For purposes of this section, "nursing home" means a twenty-four (24) hour inpatient facility, or distinct part thereof, primarily engaged in providing professional nursing services, health-related services, and other supportive services needed by the patient/resident.

906 STANDARDS FOR MEDICAID REIMBURSEMENT OF PARENTERAL AND ENTERAL THERAPY IN THE HOME

906.1 Parenteral and enteral therapy shall only be provided by home health agencies certified for participation in the D.C. Medicaid Program.

906.2 Parenteral and/or enteral therapy in the home shall only be approved if the following conditions are present:

(a) Enteral therapy shall be considered medically necessary only for a patient with a functioning gastrointestinal tract who due to pathology or non-function of the structures that normally permit food to reach the digestive tract cannot maintain weight and strength commensurate with his or her general condition. Enteral therapy may be given by nasogastric, jejunostomy, or gastrostomy tubes; and

(b) Parenteral therapy shall be considered medically necessary only for a patient with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the patient's general condition.

906.3 Prior authorization and reporting requirements shall be as follows:

(a) Providers of parenteral and enteral therapy shall obtain prior authorization from the Office of Health Care Financing before treatment is begun;

(b) To obtain prior authorization, the home health agency shall submit a written plan of treatment that has been prescribed by a physician for each patient;

(c) The home health agency shall include the name and address of the supplier(s) providing the materials, drugs, and equipment;

906 STANDARDS FOR MEDICAID REIMBURSEMENT OF PARENTERAL AND ENTERAL THERAPY IN THE HOME (Continued)

906.3 (Continued)

(d) The home health agency shall send monthly reports that detail the status of patients receiving parenteral and enteral therapy and any revisions in the plan of treatment to the Office of Health Care Financing;

(e) Verification of supplies and drugs utilized shall also be included in the monthly reports; and

(f) If the therapy period was less than one (1) month, the home health agency shall send written reports, detailing drug and supply utilization, to the Office of Health Care Financing for those patients receiving parenteral and enteral therapy at the completion of therapy.

906.4 The Office of Health Care Financing shall reimburse for professional services in accordance with the current Medicaid rates of reimbursement for home health visits.

906.5 Reimbursement for drugs and supplies shall not exceed the area prevailing charges and shall be made as follows:

(a) The home health agency shall submit invoices for medical supplies and drugs directly to the Office of Health Care Financing;

(b) The Office of Health Care Financing shall determine the appropriate amount to be paid and reimburse the home health agency; and

(c) Unless the medical record establishes that the recipient due to his or her physical or mental state is unable to safely or effectively mix solution and there is no family member or other person who can do so, generally payment shall not be made for pre-mixed solutions.

§§907-909 RESERVED

910 RESTRICTION RECIPIENT PROGRAM

910.1 The purpose of the Restriction Recipient Program shall be to control excessive or inappropriate use of medical services or goods by certain Medicaid recipients by requiring the access of these recipients to Medicaid providers be controlled by a primary care provider.

910.2 The Department of Human Services shall refer all potential Medicaid recipient restriction cases to a Restriction Review Committee of at least three (3) persons, of which at least one (1) shall be a physician.

910.3 The restriction criteria shall be set forth in the Medicaid Restriction Recipient Program Manual.

910.4 The Committee shall approve restriction of a Medicaid recipient if, as shown by Medicaid utilization reports (supplemented, as necessary, by reports from the service providers), either of the following apply:

(a) He or she uses or appears to use drugs in excess of the customary dosage for the proper treatment of the given diagnosis, or uses or appears to use multiple drugs in a manner that can be medically harmful; or

(b) He or she sees more than one (1) dentist, physician, pharmacist, or other Medicaid provider(s) at a frequency or amount that is not medically necessary for the treatment of the same health problem; Provided, that no Medicaid recipient shall be restricted for having sought a second opinion.

910.5 The Department shall notify the Medicaid recipient in writing of the following:

(a) That the Department proposes to designate him or her as a restricted Medicaid recipient;

(b) The reason for the restriction; and

(c) The recipient's right to a hearing if he or she disagrees with the designation.

910.6 A Medicaid recipient shall have fifteen (15) days from the date of the notice to file a request for a hearing with the Department's Office of Fair Hearings.

910.7 Hearing requests shall be handled in accordance with the Department's regulations governing administrative review conference and hearing procedures applicable to Medicaid recipients, published in the D.C. Register on January 11, 1980, at 27 DCR 145(a).

910 RESTRICTION RECIPIENT PROGRAM (Continued)

910.8 If the Medicaid recipient requests a hearing, no further action shall be taken on the restriction designation until the hearing is dismissed or a decision is final.

911 RESTRICTION RECIPIENTS: PRIMARY PROVIDERS

911.1 A Medicaid recipient who has been designated a restricted Medicaid recipient shall be required to select a physician and a pharmacist to be the Medicaid recipient's primary providers.

911.2 The Medicaid recipient shall make his or her selections from a list of physicians and pharmacists who are Medicaid providers and who have agreed to serve as primary providers in the restriction program.

911.3 The Medicaid recipient shall advise the Department of his or her selections within thirty (30) days of the date of the notice of restriction, or the date of final disposition of his or her request for hearing, whichever is later.

911.4 If the Medicaid recipient does not advise the Department of his or her selections within the thirty (30) day period, or does not wish to make the selections, the Department shall make the selections on the Medicaid recipient's behalf. The Department shall take into consideration reasonable access to the providers in making the selections.

911.5 Once the selections are made, the Medicaid recipient shall receive a special Medicaid identification card that indicates he or she is a restricted Medicaid recipient, and shall be advised that his or her primary physician provider must approve reimbursement for his or her medical service and that his or her selected pharmacist is the only one who can fill his or her prescriptions.

911.6 A Medicaid recipient who wishes to change his or her primary provider selection(s) may request a change by notiifying the Department. The Department may request justification for the change, and shall have thirty (30) days to review the request before approving or disapproving the change.

911.7 Restriction of the Medicaid recipient shall be for a period of one (1) year, and may be continued by the Department for additional one (1) year periods.

911.8 The Department shall notify the Medicaid recipient in writing of its proposed decision to continue the restriction, and shall advise the recipient of his or her right to request a hearing on that decision.

911 RESTRICTION RECIPIENTS: PRIMARY PROVIDERS (Continued)

911.9 If the recipient requests a hearing, his or her restriction shall continue until the decision is final or the request withdrawn.

911.10 The primary physician provider shall be responsible for general medical services to a restricted Medicaid recipient.

911.11 When the Medicaid recipient is in need of other medical services the primary provider shall make the referral to another Medicaid provider.

911.12 The primary physician provider shall fill out the special referral form which shall be attached to the other provider's bill in order for payment to be made.

911.13 The primary physician or pharmacist shall make arrangements with another Medicaid provider to authorize services for a restricted Medicaid recipient when the provider is unavailable to do so.

911.14 A physician or pharmacist who wishes to discontinue being the primary provider for any or all recipients assigned to him or her may withdraw by giving the Department thirty (30) days notice in writing; However, the primary provider shall not relinquish his or her responsibility until an alternative provider has been selected for any and all Medicaid recipients assigned to him or her.

912 REIMBURSEMENT FOR RESTRICTED MEDICAID RECIPIENTS

912.1 No Medicaid provider shall be reimbursed for goods or services provided to a restricted Medicaid recipient unless the goods or services are provided or authorized by the primary physician provider.

912.2 No pharmacist shall be reimbursed for drugs provided to a restricted Medicaid recipient unless the pharmacist is that Medicaid recipient's primary pharmacist provider.

912.3 An exception to the payment policy set forth in this section shall be made for prior authorized second opinions and emergency medical services rendered to the Medicaid recipient to prevent death or serious impairment of health.

913 REMOVAL OF ANOREXIC DRUGS FROM THE D.C. MEDICAID PROGRAM

913.1 All anorexic drugs (amphetamine and amphetamine-like) are eliminated as reimbursable pharmaceuticals from the District of Columbia's Medicaid Program, except that, Medicaid shall reimburse for anorexic drugs when prior authorization has been given by the District of Columbia's Medicaid Program.

913.2 Prior authorization shall be given for diagnosed conditions of narcolepsy and minimal brain dysfunction in children.

914 PRIOR AUTHORIZATION REQUIREMENT FOR OXYCODONE HCL AMD ASPIRIN AND FLURAZEPAM

914.1 Prior authorization shall be required for the dispensing of the following prescribed drugs:

(a) Oxycodone HCL and Aspirin (more commonly known as Percodan); and

(b) Flurazepem (more commonly known as Dalmane).

915 STANDARDS FOR NURSE-MIDWIVES' PARTICIPATION AS INDIVIDUAL PRACTITIONERS IN THE D.C. MEDICAID PROGRAM

915.1 The provisions of this section shall govern the reimbursement of nurse-midwives by the D.C. Medicaid Program for nurse-midwifery services provided as medically necessary to eligible Medical Assistance recipients.

915.2 Nurse-midwifery services shall be those services that are furnished by a nurse-midwife within the scope of practice authorized by D.C. Law 6-99, the District of Columbia Health Occupations Revision Act of 1985.

916 WHO MAY PROVIDE CARE

916.1 The nurse-midwifery services shall meet the following requirements:

(a) Be provided by a person who is licensed as a registered nurse in the District of Columbia;

(b) Meet the requirements of D.C. Law 6-99; and

(c) Execute a provider agreement with the D.C. Medicaid Program.

917 WHERE CARE MAY BE PROVIDED

917.1 Nurse-midwifery services shall be provided as follows:

(a) In a hospital on an inpatient or outpatient basis;

(b) In a free-standing treatment and diagnostic clinic or free-standing maternity center;

(c) In the office of the nurse-midwife or the physician providing collaboration and referral services; or

(d) In the recipient's home or alternative residence.

917.2 Each facility in which labor and delivery services are provided shall be licensed in accordance with District of Columbia law.

918 COLLABORATION AND PROTOCOL REQUIREMENTS

918.1 Each nurse-midwife shall maintain at all times a current, written protocol for a twenty-four (24) hour collaboration and referral pursuant to the requirements of D.C. Law 6-99.

918.2 Each nurse-midwife shall maintain and submit to the Department of Human Services a copy of the signed protocol.

918.3 Each nurse-midwife shall inform the D.C. Medicaid Program, immediately, of any termination or change in the protocol required in §918.1 of this section.

919 DIRECT MEDICAID REIMBURSEMENT

919.1 The D.C. Medicaid Program shall make direct reimbursement to a nurse-midwife who meets the requirements of §916.1 of this chapter.

919.2 The D.C. Medicaid Program shall make payment for medically necessary services which are furnished by a nurse-midwife in accordance with his or her scope of practice as permitted by D.C. Law 6-99.